Issue Briefs:

Massachusetts

Behavioral Health Analysis

Health Information Technology

Health information systems originated in claims and billing systems, followed shortly by electronic enrollment systems. Beginning in the 1980s, SAMHSA's Data Infrastructure program began to fund client treatment episode data systems in states, including Massachusetts. Doctors, hospitals, and other providers have developed and implemented Electronic Health Records (EHRs) to track clinical information and link it to claims. However, adoption of health information technology by behavioral health providers lags behind other sectors of the health care system. The Massachusetts eHealth Institute (MeHI) recently conducted a survey that found an adoption rate of 96% among primary care providers and 86% among specialty providers but only 55% for behavioral health providers.[1] Historically, many behavioral health providers have not been eligible for Medicare and Medicaid EHR incentive programs. Chapter 224 of the Acts of 2012 sought to address this gap by provided funding to assist these providers with EHR adoption. In addition to incentives, there are several other factors that affect health information technology in behavioral health:

1. The slow development of behavioral health applications by vendors;
2. Different payment and documentation requirements across states and among different payers;
3. The small size and the many different types of behavioral health programs and providers;
4. The need of many behavioral health providers for financial resources for technology investment;
5. Privacy concerns by behavioral health providers as well as patients may also play a role in the delay in implementing behavioral health treatment notes in an EHR or sharing such data through a health information exchange;
6. Differing or complex patient consent laws governing the electronic exchange of information related to substance abuse may confuse behavioral health providers and cause them to shy away from implementing electronic health records altogether.

The federal Health Insurance Portability and Accountability Act (HIPAA) provided a framework for data exchanges among payers and between providers to support treatment, payment, and operations. However, there are special privacy protections afforded to alcohol and drug abuse patient records, such as those in delineated in regulations at 42 CFR Part 2. Some worry that the exchange of behavioral health data is overly hindered by these protections, while others maintain that these protections appropriately balance confidentiality concerns with the need to exchange necessary health care information. SAMHSA has recently held a listening session on the 42 CFR Part 2 regulations.[2]

There are also special considerations pertaining to data collected and maintained by DMH and BSAS. Much of the behavioral health system for those with the most serious conditions and special populations is funded by DMH and BSAS, whose funding and data systems differ markedly from the claims based systems of health insurers. BSAS and DMH data are not part of the APCD. Both agencies

[2] SAMHSA opens door to weakening 42 CFR part 2. (2014, June 16). *Alcoholism and Drug Abuse Weekly, 26,* (4). Retrieved from http://patientprivacyrights.org/wp-content/uploads/2014/06/ADAW-June-16-2014.pdf

currently use the Commonwealth's Enterprise Invoice and Enterprise Service Management System (EIM/ESM). These two systems use a common web-based interface for invoice payment and service reporting. EIM/ESM provides licensed and contracted programs with the ability to submit encounter, assessment, and billing data for clients in treatment for substance abuse. Reports in EIM/ESM provide operational information concerning enrollment, billing, and payment status for both agencies.

For BSAS, the EIM/ESM data from encounter and bill processing are forwarded monthly to the BSAS Data Mart for reporting and analytics. However, there are some limitations with the billing data. The BSAS Data Mart environment supports the evaluation of individual client outcomes and provider program performance for those receiving or potentially needing substance abuse treatment services. Primary (EIM/ESM and SAMIS) and secondary (CHIA Hospital and Vital Registry) data sets are combined in the Data Mart, using client linking, enrollment or admission consolidation and other algorithms to create the most accurate longitudinal profile of clients possible.

DMH also uses EIM/ESM for payment of claims and can produce some client level reports. DMH also supports multiple data systems, including its electronic health record, the Mental Health Information System (MHIS) which manages enrollment data for all DMH clients. DMH links MHIS enrollment data with data reported by providers and several other datasets in the DMH Data Warehouse. Greater use in the future of client level data, including EIM/ESM data, coupled with increasing use of claims for unit rates supporting service payment (e.g. clubhouses), will allow DMH to enhance its data infrastructure.

The Center for Medicare and Medicaid Innovation (CMMI) is providing funding via a State Innovation Model grant to primary care providers and their behavioral health partners to assist both entities with the exchange of secure, electronic patient information. This funding is intended to help primary care providers and their behavioral health partners use the Mass HIway, operated by the Massachusetts' Executive Office of Health and Human Services, to exchange electronic patient information.

The Commonwealth is working both to advance adoption of health information technology by behavioral health providers and to strengthen its own data systems and analytics. This inaugural health planning effort has both demonstrated the value of cross-payer analytics, and identified areas where improvements to data systems are needed to more readily facilitate analysis.